MONTANA CHEMICAL DEPENDENCY CENTER POLICY AND PROCEDURE MANUAL

Policy Subject: Nursing Admission Process	
Policy Number: MNP 01	**Standards/Statutes: ARM 37.27.130**
Effective Date: 01/01/02	**Page 1 of 4**

PURPOSE:
To determine a new admission is medically appropriate for level III.7 in-patient treatment through a thorough nursing assessment.

POLICY:
At the time of admission, a registered nurse assesses the patient and specific admission protocols are completed.

PROCEDURE:

I. At the time of admission the nursing staff will complete an admission process that includes the following:

A. Vital signs, Breathalyzer, neuro check, height, and weight.
B. Complete nursing assessment, including review of systems, neurological status, medical and psychiatric history, and a medication history.
C. Social history.
D. Chemical use history.
E. Inventory of the individual's belongings, including removing any contraband and according to policy.
F. Completion of release of information forms.
G. Mandatory tuberculosis screening.

II. If the RN assesses a patient to be medically unstable, the RN will notify the physician on call about their findings. The physician will evaluate the patient to determine if the patient is beyond the scope of care at MCDC. In the case of an acute emergency, the nurse may not have time to concur with the physician.

A. Depending on the medical condition of the patient, the patient will be transferred to St. James Health Care, or the patient will be referred back to the community from which he was referred.

B. The patient will be rescheduled for admission at a future date, if and when the medical condition is resolved.

III. Following the nursing assessment, the nurse will notify the physician on call of the admission. The physician will make the decision if the patient is to go directly to PTU or be admitted to the Medical Treatment Unit.

A. If the patient is medically stable, shows no signs of symptoms of withdrawal, including a recorded breathalyzer of 0.0 and a reported history of no drug/alcohol use in the last 24 hours, the routine Primary Treatment Unit (PTU) orders are initiated and the patient is admitted to PTU.

B. If it is determined from the initial nursing assessment that the patient requires monitoring for withdrawal symptoms or for a non-acute medical and/or psychiatric condition, the patient is admitted to the Detox/Medical Treatment Unit (MTU) and the following procedures are initiated:

1. The routine physician DETOX orders and/or any other orders as directed from the physician are initiated.

2. For withdrawal, the vital signs are monitored at a minimum of every one to two hours while awake and every four hours while asleep and more frequently, as needed, to evaluate patient stability. Neuro checks are completed once a shift and at least hourly if abnormal. A CIWA is completed a minimum of once/shift and each time the patient is medicated with Valium. There is ongoing observation from the nursing staff and documentation of the patient's condition at a minimum of every two hours, depending on the patient's medical condition/stability.

3. The nursing staff initiates and updates dimension 1 of the treatment plan during the patient's stay in detox.

4. Depending on the patient's level of orientation and abilities, assistance with ADL's and bathing will be provided as necessary.

5. The nursing staff communicates on a daily basis with the counselors and mental health staff regarding the patient's condition and progress while in detox. Communication between the nursing staff and counseling staff is documented in the progress notes.

6. A patient on the MTU receives their meals on the unit with trays delivered from the food service three times a day, with snacks provided as necessary. Assistance with eating is provided as necessary.

7. The length of stay in the MTU unit is variable. As soon as the physician determines that the patient is medically stable, the patient is transferred to the PTU.

IV. The patient will receive a physical examination within 72 hours of admission.

V. The patient will receive routine blood and urine laboratory testing, unless otherwise ordered by the medical Administrator. Also voluntary HIV, Hepatitis C, and Chlamydia testing are offered to the patient at the time of admission.

VI. The nursing staff will monitor the PTU patient's vital signs twice a day for the first three days of admission. Any abnormal readings will be brought to the physician's attention.

VII. The assigned treatment specialist completes a patient orientation when the patient arrives on the PTU. The orientation includes a copy of the patient handbook and patient rules and expectations. It also covers safety issues and schedules.

VIII. The PTU patient receives three meals plus per day plus snacks. There is a pantry located on each patient floor that is stocked peanut butter, jelly, and bread. If a patient has a special dietary need such as a diabetic or a patient has specific food allergies, the following procedure is completed by the admitting nursing staff:

A. A special diet form will be filled out with the special diet and/or food allergies. These forms are in triplicate:

1. The white copy is taped in the patient's medical chart on the patient photo sheet.

2. The yellow copy is placed in the dietary box located at nursing station. Daily, night shift is to deliver any dietary forms (yellow copies) to the kitchen in the early morning.

3. The pink copy is to be placed in the MAR next to the patient picture.

B. At the time of discharge, the pink copy is removed from the MAR and discharged is written across it. It is then placed in the dietary box. Night shift nursing staff will take any; pink copy discharged dietary forms to the kitchen each day.

IX. POSSIBLE RESTRICTIONS TO CONTINUED ADMISSION:

A. Serious heart disease.
B. Evidence of acute pulmonary disease.
C. Evidence or recent history of head trauma.
D. Evidence or recent history of recent bodily trauma, requiring possibly x-ray procedures or diagnosis.
E. Evidence or suspicions of serious infection requiring acute care management, including suspicion of infectious tuberculosis.
F. Uncontrolled diabetes.
G. Barbiturate withdrawal.
H. Abnormal vital signs, acute, including:
I. Pulse > 130, < 50.

J. Respiration's> 28 minutes.
K. Blood pressure > 180/120, < 80/50
L. Temperature < 95 degrees F, > 103 degrees F
M. Active gastrointestinal bleeding, including hematemesis or melena.
N. Evidence or suspicion of acute hepatitis or advanced liver failure.
O. Condition requiring IV therapy.
P. Unstable mental illness.
Q. Violent, uncontrollable, or threatening behavior.
R. Acute intoxication and/or overdose.
S. Any medical condition or complication that meets criteria for admission to an acute facility.

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